

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG NO. 2910											
1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR 16 6 87									
1 DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM MIDDLE PARKS LAST ABBOTT, Sr.			7b HOUR 3:30 AM						
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH 08 DAY 06 YEAR 02		6 AGE IN YEARS (LAST BIRTHDAY) 85		IF UNDER 18 YRS			
7a BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester					
10 CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b KIND OF BUSINESS OR INDUSTRY Shellfish			
13a STATE Md.		13b COUNTY Dorchester		13c CITY OR TOWN Toddville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Box 232 21672			
14 FATHER'S NAME FIRST MIDDLE GEORGE CHARLES		14b MOTHER'S NAME FIRST MIDDLE ABBOTT Lola Abbott		15 MOTHER'S MAIDEN NAME FIRST MIDDLE		16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b SOCIAL SECURITY NO. 214-10-0545		17 INFORMANT Wife ADDRESS Monnie M. Abbott, same as 13e	
18 CAUSE OF DEATH Enter only one cause per line for item 1b, and if applicable, for item 19. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest											
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF b) CVA & hypertension											
} DUE TO, OR AS A CONSEQUENCE OF c) My previous cardiovascular disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Severe disorder, COPD											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART II & PART III)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) this hospital attended the deceased from 1986, 19, to 10-6-1987 that (ii) we last saw the deceased alive on 9-29-87, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) We did not view the body after death.											
22b SIGNATURE Michael J. Falder		22c DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED OCT 09 1987					
22e PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Falder MD		22f ADDRESS 800 Collins, Harford Md 21643									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE 10/8/87		23c NAME OF CEMETERY OR CREMATORIAL Wesley Church Cem.		23d LOCATION CITY OR TOWN Andrews, Dorchester, Md.					
24 FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St. Cambridge, Md. 21613		25a DATE REC'D. BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE Michael J. Falder							

8378 CCI 130

Wash Ave. 1000

20 40 50 70 90 110 130 150

Reinforced

20

Concrete Slab - Reinforced

Parapet

20 40 50 70 90 110 130 150

Slab Attached

20 40 50 70 90 110 130 150

20 40 50 70 90 110 130 150

180 20 130

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed in by the funeral director. Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be informed at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

29591

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.
LOTTIE ELOISE					BRADSHAW	OCT 13 1987
3 SEX	4 RACE	5 DATE OF BIRTH	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR
female	white	Sept 2, 1905	Oct 13 1987			12:50 AM
7a BIRTHPLACE (COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 18 MONTH DAYS HOUR MIN
Cambridge		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	82			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12e USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cambridge	Dorchester General Hospital			homemaker		
13a STATE MD.	13b COUNTY Dor.	13c CITY OR TOWN Church Creek	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE St. Rt. 335 21622		
14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME Lillie	MIDDLE	14b KIND OF BUSINESS OR INDUSTRY Lord	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b SOCIAL SECURITY NO 212-40-7650	17 INFORMANT M. Lloyd Bradshaw	ADDRESS Box 632 Church Creek Md.	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  (b) <u>CARDIO - PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF  (c) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF  (d) <u>ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour  4 years  4 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				
21d INJURY OCCURRED WHITE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET	21g CITY OR TOWN	21h COUNTY	21i STATE	
22a I certify that (I) this hospital attended the deceased from 1985, 19 to Oct 13, 1987 that (we) lost saw the deceased alive on Oct 13, 1987 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b SIGNATURE Michael A. Moskowicz	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED Oct 13, 1987			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Moskowicz	22e ADDRESS 503 34th St. Cambridge MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b DATE 10/15/87	23c NAME OF CEMETERY OR CREMATORIAL St. Johns Churchyard	23d LOCATION Golden Hill	23e CITY OR TOWN Dor.		
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME	ADDRESS CAMBRIDGE MD.	25a DATE REC'D. BY REGISTRAR OCT 22 1987				



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 29598

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Coleman Wheatley Cook</i>						10	24	87	120 PM		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		August 30, 1908		79 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD			
Maryland		US				Dorchester Co.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General Hospital				Bricklayer					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Dorchester		Cambridge				Rt 1 Box 162		21613	
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Herman		G.		Cook		Arthur		Agnes		Wheatley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO				17 INFORMANT		ADDRESS			
No		214-07-7305				Louise Windsor Item # 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Cardio-Pulmonary Arrest											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DO TO, OR AS A CONSEQUENCE OF (b)					
						Possible ruptured abd. aneurysm					
DO TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>AS CVD</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____ that (I) (we) last saw the deceased alive on _____ 19_____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b SIGNATURE <i>Scamman</i>		22c DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE Burial 10/27/87		23c NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park		23d LOCATION CITY OR TOWN Cambridge, Dor. Md.		23e COUNTY		23f STATE	
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE <i>Julia Gordon-Ladree</i>							

100-111 101010

18

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1100

100-111 101010

069877 OCT 27 87 29598  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTIMATED	MONTH	YEAR	2b HOUR
MICHAEL EVAN						Daringer	X	10	11	1987
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE IN YEARS (LAST BIRTHDAY)	7 IF UNDER 1 YR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD	MONTH	YEAR	2d HOUR	
male	white	07/15/1960	27 yrs			X	10	18	1987	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		9 BALTIMORE CITY OR COUNTY OF DEATH				
N.Y.		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED		Dorchester County MD				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MORE OF WORKING (IF))		12b KIND OF BUSINESS OR INDUSTRY		
Golden Hill		woods off Oldfield Rd.								
13a STATE MD.		13b COUNTY Dor.		13c CITY OR TOWN Cambridge		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 4 Box 192 21613		
14 FATHER'S NAME FIRST Ronald		MIDDLE G.		LAST Daringer		15 MOTHER'S MAIDEN NAME FIRST Dolores		LAST Anderson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c		17 INFORMANT		ADDRESS		
Yes		1986-1987		219-70-8319		Ronald G. Daringer		Item 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of neck</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY, YEAR P.M. 10 11 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self inflicted				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM ETC.) woods		21f LOCATION STREET off Oldfield Rd, Golden Hill,		CITY OR TOWN Dorchester, MD.		COUNTY STATE		
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Mario F. Golle Jr.</i>		TITLE (SPECIFY) Assistant				DATE SIGNED 10/19/87				
EXAMINER'S NAME (TYPE OR PRINT)		Mario F. Golle, Jr., M.D.				ADDRESS 111 Penn St.		Balto., MD.		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b DATE 10/20/87		23c NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.				23d LOCATION CITY OR TOWN Baltimore		
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE		

WES 103 15-3800



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Detach here. *For more carbon copies, pages 1 & 2 should be filed within 72 hours after death.*

IMPORTANT If item 21 is marked or item 18 shows any of the following conditions, notify the State Dept. of Health and Mental Hygiene prior to burial:

*(1) Death from drowning, electrocution, lightning, or removal of body from water.*

*(2) Death from drowning, electrocution, lightning, or removal of body from water.*

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												29000	
												REG. NO.	
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			Stella Johnson Dean						Oct 14 1987			11:05 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 18 YEAR MONTH DAY YRS			7 IF UNDER 21 HRS HOURS MIN			
Female		White		October 14, 1985			82						
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD			
Maryland		US					Dorchester Co.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Cambridge		Cambridge House		Homemaker.									
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			
Maryland		Dorchester		Cambridge						520 Glenburn Ave. 21613			
14 FATHER'S NAME FIRST		MIDDLE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Aaron		Johnson		Vertie Robinson									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT			ADDRESS			21			
No		216-48-6064		Diane Bartz 109 Simms Dr.			Annapolis, Md.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <i>Lymphoma</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I & PART II)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 8/19/86 to 10/18/87 that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c DATE SIGNED 10/14/87	
22b SIGNATURE <i>Mary Ann D. Moore MD</i>		22c DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary Ann D. Moore MD</i>		22e ADDRESS 404 Byrn St, Cambridge, MD 21613											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/87		23c NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park			23d LOCATION CITY OR TOWN County State Cambridge Dor Md.						
24 FUNERAL DIRECTOR THOMAS FUNERAL HOME CAMBRIDGE, MD.				25a DATE REC'D BY REGISTRAR OCT 22 1987			25b REGISTRAR'S SIGNATURE <i>John D. Moore</i>						

168263-00280

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168263-00280

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO. 29601

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Robert</i>			<i>Emmett</i>	<i>Dewlin</i>		10	26	87	11 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 HOUR DAYS	IF UNDER 1 MIN HOURS		
MALE	white	2 24 20				67	YRS				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY	7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
maryland	US						Dorchester Co. MD				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Cambridge	Dorchester General Hospital					Surveyor					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE					
Maryland	Dorchester	Cambridge				Rt 3 Box 219 21613					
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
George	Mason		Dewlin				Hester	Ann	Roach		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO					17 INFORMANT	ADDRESS				
Yes WW II	219-07-4289					Ruth S. Dewlin Item # 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
Ca of lung											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											
(b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Coronary A. Disease											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED  WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from _____ 19_____ to _____ 19_____ that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <i>G. Cameron</i>	22c DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d DATE SIGNED 10-27-87						
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE 10/29/87	23c NAME OF CEMETERY OR CREMATORIAL Dor Mem Park			23d LOCATION CITY OR TOWN Cambridge Dor Md. COUNTY STATE						
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.	ADDRESS			25a DATE REC'D BY REGISTRAR OCT 30 1987							
25b REGISTRAR'S SIGNATURE											

102-108 288050



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 29602

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
William Ellsworth Dietrich						Dietrich	10/15/87				2348
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male		White		MONTH	DAY	YEAR	68			MONTHS	YEARS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 HR.	
Maryland		US		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester Co.			HOURS MIN.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester General Hospital					Mechanic				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Dorchester		Cambridge		XX		Rt 1 Box 238 EE 21613			
14 FATHER'S NAME FIRST		MIDDLE		LAST	15 MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Benjamin		Franklin		Dietrich	Ida		Mae		Riley		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
No		214-07-7872		Pauline J. Dietrich		Item # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gastric Lymphoma</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CPT of ASHD</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>an Pulm Embolism</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19a		19b						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/28/87</u> to <u>10/15/87</u> that (I) (we) last saw the deceased alive on <u>10/8/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Ellsworth</i>		22c DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <u>10/16/87</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>VINODRAI MEHTA</i>		22e ADDRESS <i>400 Aurora St. Cambridge MD 21613</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/8/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor Mem Park		23d LOCATION CITY OR TOWN Cambridge Dor		COUNTY		STATE Md.	
24 FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME CAMBRIDGE, MD.</i>		ADDRESS		25a DATE REC'D BY REGISTRAR <u>OCT 09 1987</u>		25b REGISTRAR'S SIGNATURE <i>J. Miller</i>					

RECEIVED JUN 8 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										29603		
FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
BRICE			E		Johnson	10 25		87		8:00 AM		
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 HOUR		
Male			White	MONTH	DAY	YEAR	88		MONTH	DAY	HOURS	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD.			U.S.A.				Dorchester		MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bishops Head			at home		waterman							
13a. STATE MD.			13b. COUNTY Dor.	13c. CITY OR TOWN Bishops Head	14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS UNKNOWN		ZIP CODE		21611	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Lena		MIDDLE		LAST		Ruark	
Charles Goldsborough Johnson												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 217-16-9270		17. INFORMANT Phyllis J. Mills		ADDRESS Box 35 Bishops Head Md.					
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ruptured aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from <u>8/20/87</u> to <u>10/25/87</u> , that (2) we last saw the deceased alive on <u>10/25/87</u> 19 <u>87</u> and that in my (my) opinion death occurred on the date and hour and from the causes stated above, (3) we did not view the body after death.												
22b. SIGNATURE <u>MaryAnn S. Moorehead</u>			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>10/25/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MaryAnn S. Moorehead</u>			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 10/27/87	23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEMORIAL PK.		23d. LOCATION CITY OR TOWN CAMBRIDGE, DOR., MD.		23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Jackson-Lindell</u>					

W.C.-104-A78050

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. The permit may be removed carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <b>EMMA</b>	Middle	Lost	2d. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>87</b>	2b. HOUR M	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH <b>12/22/1924</b>		6. AGE (In years lost birthday) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Dorchester Co.</b>			
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Dorchester Gen</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Taper</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Bradley Agency</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>614 Bradley Agency</b>			
14. FATHER'S NAME First <b>William Kid Nelson</b>	Middle	Last	15. MOTHER'S MAIDEN NAME First <b>Boise</b>	Middle	Last <b>Nichols</b>	Address	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>218-16-7535</b>		17. INFORMANT <b>Fannie Stevens</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY:  <b>IMMEDIATE CAUSE (a)</b> <i>Cardiopulmonary Arrest</i>  <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>Conditions, if any, which gave rise to immediate cause (a)</b> <b>(b)</b> <i>Disorders complicated by Cardio- Vascular Dis.</i>  <b>DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b> </p>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael Joyce MD</i>		22c. DATE SIGNED <b>10/30/87</b>					
22d. PHYSICIAN'S NAME (Type) <b>DR. MICHAEL JOYCE M.D.</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10/30/87</b>		23b. DATE <b>10/30/87</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>V. P. Cem.</b>	23d. LOCATION (City or Town) <b>Hawthorne Md.</b>	(County) <b>Hawthorne</b>	(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Stewart Funeral Home Camb. Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>NOV 03 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Dawson-Landale</b>			

St. 121-155030

121-155030

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRUST FEE. PART PERMIT PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												29005			
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTIMATED				REG. NO.	MONTH	DAY	YEAR	2b HOUR	
ROBERT					McGEE JR	<input checked="" type="checkbox"/> 10-16 1987					10-16	1987		11:57 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) 57 yrs.	7 IF UNDER 1 YR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d HOUR		
M	CAUCASIAN	10-7-30				<input checked="" type="checkbox"/> 10-17 1987					10-17	1987		12:17 PM	
7a BIRTHPLACE COUNTRY	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED NEVER MARRIED WIDOWED DIVORCED				9 BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND	U.S.	<input checked="" type="checkbox"/>				DORCHESTER				MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY					
DANBURY	DORCHESTER GENERAL HOSPITAL					NURSE				PUMP CO.					
13. STATE	14. COUNTY	15. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET ADDRESS								
MD	PASADENA	PASADENA	<input checked="" type="checkbox"/>				1336 EDNA RD. 21122								
16. FATHER'S NAME	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME				16 ADDRESS								
ROBERT		McGEE	ANNA				WHITE								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b SOCIAL SECURITY NO.					17 INFORMANT				18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
YES	KOREAN CONFLICT 218-26-9407					HOSPITAL RECORDS DORCHESTER GEN HOSP				DEMENTIA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
IDIOPATHIC HYPERTROPHIC SUBAORTIC STENOSIS															
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY?									
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21a EXTERNAL CAUSE OF DEATH UNDERLYING CAUSE CONTRIBUTING TO DEATH	21b TIME OF INJURY HOUR A.M. MINUTE DAY YEAR P.M. 19					21c HOW INJURY OCCURRED NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2									
						N/A									
21d INJURY OCCURRED WHILE AT WORK	21e PLACE OF INJURY STREET, CITY, STATE, ZIP					21f LOCATION STREET N/A				CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Donald R. Synder												TITLE (SPECIFY) M.D. MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) DONALD R. YEDD M.D.												DATE SIGNED 10/17/87			
ADDRESS 308 GAY ST. CAMBRIDGE, MD. 21613															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORIAL MEADOWBRIDGE MEM. PARK					23d LOCATION CITY OR TOWN ENRIDGE				COUNTY STATE HOWARD MD				
BURIAL	OCT. 21, 1987														
24 FUNERAL DIRECTOR NAME	ADDRESS 3204 MOUNTAIN RD McCULLY FUNERAL HOMES PASADENA, MD 21122					25a DATE REC'D. BY REGISTRAR OCT 20 1987				25b REGISTRAR'S SIGNATURE Evelyn Rondell					

BP \_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M 2/80

161X-25880

50000

50000

50000

50000

1.2

1.2

1.2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE KEPT (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL).

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 069942 OCT 27 1987											
DECEASED NAME (TYPE OR PRINT)			FIRST <i>Joseph</i>	MIDDLE <i>Thomas</i>	LAST <i>Moore</i>	2a DATE KNOWN OF DEATH ESTI- MATED			MONTH <i>X 10</i>	DAY <i>25</i>	YEAR <i>87</i>
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH <i>9</i>	DAY <i>a</i>	YEAR <i>38</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>49</i>	IF UNDER 1 YR. MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	2b HOUR <i>12 AM</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester County</i>			
10 CITY OR TOWN OF DEATH <i>Cambridge</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Computer Operator</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Banking</i>			
13a STATE <i>Md.</i>		13b COUNTY =====		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>816 S. 30th Street 21225</i>			
14. FATHER'S NAME FIRST <i>Jay</i>		MIDDLE <i>M.</i>	LAST <i>Moore</i>	15 MOTHER'S MAIDEN NAME FIRST <i>Gloria</i>		MIDDLE <i>I.</i>	LAST <i>Gillespie</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b SOCIAL SECURITY NO. <i>1957-1959</i>		17 INFORMANT <i>Gloria I. Beth 7733 Telegraph Rd #40</i>		ADDRESS <i>Severn, Md 21144</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the immediate cause (a) stating the under- lying cause last. (b) <i>Severe coronary sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Peter W. Rieckert</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			DATE SIGNED <i>10.25.87</i>						
EXAMINER'S NAME (TYPE OR PRINT) <i>Peter W. Rieckert</i>		ADDRESS <i>E. New Market, Md. 21631</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/29/87			23c NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>			23d LOCATION CITY, TOWNSHIP <i>Baltimore</i>			
24. FUNERAL DIRECTOR NAME <i>George J. Goncze</i>		ADDRESS <i>4001 Ritchie Hwy Balto Md</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 26 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Leedell</i>			

WES 10-3 10820

WES 10-3 10820

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

Retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then give it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 23 shows any injury or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2900			
REG NO.													
1 DECEASED NAME (TYPE OR PRINT)		FIRST LOIS		MIDDLE W.	WINFIELD		LAST MURPHY	2d DATE OF DEATH		MONTH Oct.	DAY 8, 1987	YEAR 1987	2d HOUR 10:20 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7 IF UNDER 18 YEARS LAST BIRTHDAY		8 IF UNDER 18 YEARS		9 BALTIMORE CITY OR COUNTY OF DEATH	
male		Caul		Sept. 30, 1904		83 YRS						DORCHESTER MD	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE		DORCHESTER GENERAL HOSPITAL		WATERMAN		SHELLFISH							
13a STATE		13b COUNTY		13c IS IT WITHIN THE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		BISHOP'S HEAD, MD					
MARYLAND		DORCHESTER				GENERAL DELIVERY, 21611							
14 FATHER'S NAME		FIRST WINFIELD	MIDDLE P.	LAST MURPHY	15 MOTHER'S MAIDEN NAME		FIRST GLENNIE	MIDDLE F.	LAST MURPHY				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		220-18-3581		wife		3 day							
220-18-3581		MRS. DORA P. MURPHY, same as 13e											
18b CAUSE OF DEATH Enter only one cause per line for a, b, and c PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____													
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Dehydration, atrial fibrillation, progressive dementia</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART III)									
21d INJURY OCCURRED  WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY AT HOME STREET FACTORY OFFICE FARM ETC.		21f LOCATION STREET _____ CITY/TOWN _____ COUNTY _____ STATE _____									
22a I certify that I (the physician) attended the deceased from <u>10/13/87</u> to <u>10/18/87</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. I (the physician) did not view the body after death.													
22b SIGNATURE <u>HUBERT L. Ferry</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/18/87</u>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. Ferry</u>		22e ADDRESS <u>503 BYRN ST</u>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b DATE <u>10/11/87</u>		23c NAME OF CEMETERY OR Crematory <u>DORCHESTER MEM. PK. AIREY, DORCHESTER, MD.</u>		23d LOCATION <u>STATE</u>							
24 FUNERAL DIRECTOR CURRAN FUNERAL HOME NAME <u>A.C. CURRAN</u> 308 HIGH ST., CAMBRIDGE, MD. 21613										25a DATE REC'D. BY REGISTRAR <u>OCT 15 1987</u>		25b REGISTRAR'S SIGNATURE <u>Suzie Davidson Pendell</u>	

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200 CONSTITUTION



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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 2900	
1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH DAY YEAR	2b HOUR 20 12 PM
Rosa E Parks				10/1/87		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDERTAKER BUREAU DATE		7b HOUR 12 PM
Fe	White	4 10 94	93 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			MD.
MD.	U.S.A.		Dorchester			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Cambridge	Dorchester General Hospital			homemaker		
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)					13e STREET ADDRESS / ZIP CODE	
13a STATE Md.	13b COUNTY Dor.	13c CITY OR TOWN Wingate	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	UNKNOWN		21675
14. FATHER'S NAME	FIRST Asbury	MIDDLE Levin	LAST Wingate	15 MOTHER'S MAIDEN NAME	16. ADDRESS	
				Sara	Johnson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO	218-34-8193	John Parks	Cambridge Md.			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CVA c bsp						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b	19c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21a OR PART 2)			20c		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c	21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) 21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____			
21b	21c	21d	21e	21f		
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10/6 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death	22b SIGNATURE <i>Un weiter</i>	22c DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d PHYSICIAN'S NAME (TYPE OR PRINT) VANORSA MEHTA	22e ADDRESS 400 Aurora St. Cambridge Rd 21613.	22f DATE SIGNED 10/7/87
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE burial 10/9/87	23c NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK	23d LOCATION CITY OR TOWN CAMBRIDGE DOR. MD.	25a DATE REC'D. BY REGISTRAR OCT 09 1987	25b REGISTRAR'S SIGNATURE <i>Jeanne Dearden Randal</i>	
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME	ADDRESS CAMBRIDGE MD.					
DHMH - 16 60M 7/84 (VRA 15, 4)						

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be left in the hands of the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG NO. 29509
1. DECEASED NAME (TYPE OR PRINT) <i>Wilsie R. Slacum</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10-22-87</i>		2b HOUR <i>7:30 PM</i>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <i>Oct 30 1913</i>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS	7. UNDER 1 YEAR <input type="checkbox"/> 8. UNDER 24 HRS <input type="checkbox"/> MONTHS DAYS HOURS MIN	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY <i>Md.</i>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Dorchester</b> MD		
10. CITY OR TOWN OF DEATH <b>Cambridge</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dorchester General Hosp.</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>	
13a STATE <b>Md.</b>	13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <b>Cambridge</b>	13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>325 Dorchester Ave. 21613</b>	
14. FATHER'S NAME FIRST <b>Ernest</b>	MIDDLE <b>Ruark</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Meddie</b>	MIDDLE	LAST <b>James</b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NO</b>	16c INFORMANT <b>Emerson B. Slacum</b>	ADDRESS <b>Item # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1d</b>		
Conditions, if any, which gave rise to immediate cause (b) <i>Oat Cell Lung Cancer</i>			2 mos		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Oat Cell Lung Cancer</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a I certify that (1) this hospital attended the deceased from <i>3EP</i> 19 87 to <i>10-22</i> 19 87 that (2) we lost saw the deceased alive on <i>10-22-87</i> 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) we did not view the body after death.					
22b SIGNATURE <i>Craig W Caldwell MD</i>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>10-22-87</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Craig W Caldwell</i>	22e ADDRESS <b>DORCHESTER GENERAL HOSP, CAMBRIDGE, MD</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>	23b DATE <b>10/25/87</b>	23c NAME OF CEMETERY OR CREMATORIAL <b>E. NEW MARKET CEM.</b>	23d LOCATION CITY OR TOWN <b>E. NEW MARKET, DOR., MD.</b>	23e DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b>	
24. FUNERAL DIRECTOR NAME <b>THOMAS FUNERAL HOME</b>	25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE <i>Julia Southern-Laddie</i>				
DHMH - 16 60M 7-B4 (VRA 15, 4)					

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Gladys G. Stevens						10.12.87				755A <sub>m</sub>	
3 SEX		4 RACE	5 DATE OF BIRTH			6 AGE	IN YEARS; LAST BIRTHDAY				
Female		White	MONTH	DAY	YEAR	78	IF UNDER 18 yrs	AGE	MONTH	DAY	
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?	8			9	9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
W. Va.		U.S.A.	MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	Dorchester				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Cambridge		Eastern Shore Hospital Center			Homemaker			Home			
13a STATE MD.		13b COUNTY Cecil		13c CITY OR TOWN North East		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 25 Rail Road Rd. 21901			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
Rastes Grimmit		Unknown									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		235-28-5175		Diane Gray		14 Elk Hill Ct. Elkton, Md. 21921			O		
18 CAUSE OF DEATH Enter only one cause per line for a, b, and c PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO OR AS A CONSEQUENCE OF b) <u>Cardiac Congestive failure</u> } DUE TO OR AS A CONSEQUENCE OF c) <u>Cardiac arrhythmia</u>											
9/29/87 4/20/87											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Hypertension, Diabetes, Arthritis</u>											
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)						
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e PLACE OF INJURY LAT HOME STREET FACTORY OFFICE FARM ETC.			21f LOCATION STREET		CITY OR TOWN			COUNTY STATE	
22a I certify that I (this hospital) attended the deceased from 2-6 - 1985 to 10-12 1987 that I (we) last saw the deceased alive on <u>Name</u> 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If we certify, view the body after death.											
22b SIGNATURE <u>Rosey J. M.</u>		22c DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d DATE SIGNED 10/13/87				
22d PHYSICIAN'S NAME					22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-15-87			23c NAME OF CEMETERY OR CREMATORIUM North East Meth.		23d LOCATION North East Cecil Md.				
24 FUNERAL DIRECTOR Name Honey Funeral Home		24 DATE REC'D. BY REGISTRAR OCT 15 1987			25b REGISTRAR'S SIGNATURE <u>Lia Barker Pendleton</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this certificate be executed within 24 hours after death. Page 4 may be

renewed by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by you as the burial/transit permit then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal  
IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event the medical examiner

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Page 4 may be

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2961		
1 - FOR STATE REGISTRAR			REG NO.									
1a DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
KED LEWIS WANEX							10-17-87					2547M
3. SEX MALE			4 RACE WHITE		5 DATE OF BIRTH NOVEMBER 15, 1903		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 14 HRS HOURS	
7a BIRTHPLACE COUNTRY MARYLAND			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY MD					
10 CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN/FARMER		12b KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED					
13a STATE MARYLAND			13b COUNTY DORCHESTER	13c CITY OR TOWN EASTNEWMARKET	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE WARWICK ROAD/21631					
14 FATHER'S NAME JOSEPH			15 MOTHER'S MAIDEN NAME ANTOINETTE									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO NO - 216-16-7308		17 INFORMANT RT. 1, BOX 180 ANNA LEE WANEX, EAST NEW MARKET, MD 21631							
18 CAUSE OF DEATH (Enter only one cause per line for items b and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>BASIC Deter</i> DUE TO, OR AS A CONSEQUENCE OF b) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF c) <i>Generalized Arteriosclerosis Cardiac Arrest - SCYMS</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs (approx)</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												<i>3 hrs (approx)</i>
19a MEDICAL CERTIFICATION DATE OF OPERATION N/A			19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b OR PART 2) N/A							
21d INJURY OCCURRED WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A		21f LOCATION STREET N/A		CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from saw the deceased alive on <u>10/17/87</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.			22b DEGREE D.S. Williams MS		22c DATE SIGNED 10-12-87							
22d PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. WILLIAMS, M.D.			22e ADDRESS 308 Gray Street, Cambridge, MD 21613									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 10-20-87		23c NAME OF CEMETERY OR CREMATORIAL OUR LADY OF GOOD COUNSEL, SECRETAY, DORCHESTER, MD		23d LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631			25a DATE REC'D. BY REGISTRAR NOV 6 1987		25b REGISTRAR'S SIGNATURE <i>Randall</i>							
DHMH - 16 60M 7 BA (VRA 15, 4)												

051502 00000

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070539 NOV -31

be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

rejoined by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2901					
1 - STATE REGISTRAR				REG. NO.				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1c. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		10-29-87				8:33 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 18 YEARS MONTHS DAYS		8. IF UNDER 21 HRS HOURS MIN.					
Male		Black		10 13 81		66 yrs									
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Dorchester MD.							
South Carolina		U.S.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Cambridge							
Cambridge		Dorchester General		Laborer		Manufacturing		21613							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		614 Race St. Cambridge, Md.					
Md.		Dorchester		Cambridge				614 Race St. Cambridge, Md.							
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS 117 Salisbury Ave.			
Samuel		Wilder		Linda		Yes		1941-1943 249-126143		Donna Bohaker		Cambridge, Md.			
18. CAUSE OF DEATH Enter only one cause per line for 18, b, and c. PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes			
Respiratory Arrest		Massive Hemoptysis		Squamous cell carcinoma of the lung								30 minutes 1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED  WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET						CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (he) (she) attended the deceased from saw the deceased alive on Oct 29 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (she) did not view the body after death		22b. SIGNATURE Edmund J. MacLaughlin MD		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10/29/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin		22e. ADDRESS 10 Aurora St. Cambridge, Md 21613													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-3-87		23c. NAME OF CEMETERY OR CREMATORIAL Rolling Green		23d. LOCATION West Chester Pa.		25a. DATE REC'D. BY REGISTRAR NOV 02 1987				25b. REGISTRAR'S SIGNATURE Julia Scidmore-Lundeen			
24. FUNERAL DIRECTOR NAME Bennie L. Smith P.O. Box 928 Md.		ADDRESS Hawlock													

REC-100 882070

enough

X 3/21/88

371262 NOV-987  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG NO						
1- STATE REGISTRAR			2 DATE KNOWN OF DEATH MONTH DAY YEAR							2d HOUR						
DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		<input type="checkbox"/>	10	16	19	87	8:50 PM		
Arthur (NMI)							Willey		<input type="checkbox"/>							
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR		IF UNDER 24 HRS		7c DATE MONTH DAY YEAR		7d HOUR						
Male	White	July 17, 1919	68 yrs	MONTH	DATE	HOURS	MIN	10	16	19	87	8:50 PM				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED WIDOWED		9 DATE MONTH DAY YEAR		9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		10		16		19	87	9:50 PM		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b KIND OF BUSINESS OR INDUSTRY			
Cambridge			Dorchester General							Maintenance			State Govm't			
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS							
Maryland			Dorchester		Secretary		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Wes and Main Streets/21664							
14 FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST				
George			Edward		Willey		Carrie					Martin				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS			P. O. Box 100					
Yes			WWII			220-10-6258		Goldie Jane Ann Willey, East New Market			MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) CARDIAC ARREST													IMMEDIATE			
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost																
(b) CARDIAC DYSRHYTHMIA OR													MINUTES			
DUE TO, OR AS A CONSEQUENCE OF																
(c) ACUTE MYOCARDIAL INFARCTION													MINUTES			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a																
N/A			N/A													
19a DATE OF OPERATION N/A			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A										20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH N/A			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY STREET FACTORY N/A			21f LOCATION STREET N/A			CITY OR TOWN		COUNTY	STATE				
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			
EXAMINER'S NAME TYPE OR PRINT) Donald R. McWilliams, M.D.													DATE SIGNED 10-20-87			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE Burial		23c NAME OF CEMETERY OR CREMATORIAL MD Eastern Shore Vet. Cem., Beulah, Dorchester, MD			23d LOCATION CITY OR TOWN		COUNTY		STATE				
24 FUNERAL DIRECTOR NAME Zeller Funeral Home,			ADDRESS East New Market, MD			25a. DATE REC'D. BY REGISTRAR NOV 6 1987		25b. REGISTRAR'S SIGNATURE								
25c. DHMH - 17 (VR A15 ME 15)																

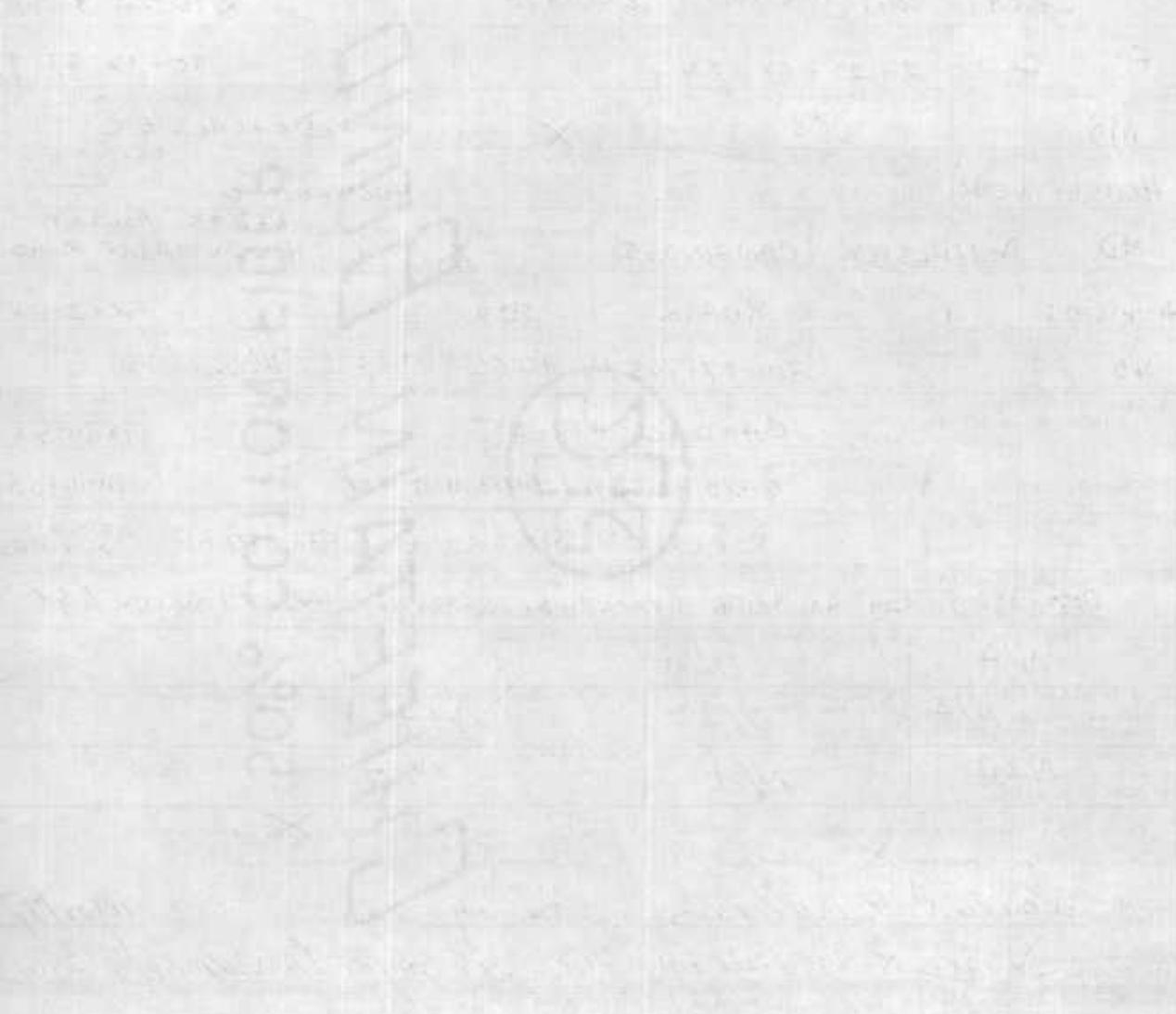
500-101 S.A.S.I.S

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE FACSIMILE NUMBER AND ADDRESS TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 3 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29614					
1 - STATE REGISTRAR			1a. DECEASED NAME OR PRINT DORA			1b. FIRST MIDDLE LAST WASHINGTON WINGATE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10-22 87			2b. HOUR 7:30 AM					
1c. SEX F			1d. RACE C			1e. DATE OF BIRTH MONTH DAY YEAR 2-27-03			1f. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.			1g. IF UNDER 1 YR. MONTHS DAYS			1h. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
1i. BIRTHPLACE STATE OR FOREIGN COUNTRY MD			1j. CITIZEN OF WHAT COUNTRY? U.S.A.			1k. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			1l. DATE PRONONCED DEAD MONTH DAY YEAR 10-22 87			1m. HOUR 9:00 AM					
1o. CITY OR TOWN OF DEATH HUDSON (WEAR)			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hudson Wharf Rd. (home)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MD			13b. COUNTY DORCHESTER			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD #3 Box 229 HUDSON WHARF ROAD					
14. FATHER'S NAME AUGUSTUS I RUAJK						15. MOTHER'S MAIDEN NAME XXXXXX IDA						16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-07-7657			16c. MR. DUANE MARSHALL, ADDRESS 102 JOHNSON ST. XXXXXXXXXXXXXX CAMBRIDGE, MARYLAND 21613											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY			19. IMMEDIATE CAUSE (a)			20. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			21. DUE TO, OR AS A CONSEQUENCE OF (b)			22. DUE TO, OR AS A CONSEQUENCE OF (c)					
						CARDIAC ARREST											
						CARDIAC DYSRHYTHMIA OR											
						RECURRENT MYOCARDIAL INFARCTION						WITHIN MINUTES					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
23a. DATE OF OPERATION N/A			23b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A			23c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
24a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH N/A			24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			24c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A											
25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOWHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			25b. PLACE OF INJURY STREET, FACTORY, FARM, ETC. N/A			25c. LOCATION STREET N/A			25d. COUNTY			25e. STATE					
26a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			26b. TITLE (SPECIFY) ACTUAL SIGNATURE Donald L. Newbill, M.D. DEPUTY MEDICAL EXAMINER			26c. DATE SIGNED 10/22/87											
26d. EXAMINER'S NAME DONALD L. NEWBILL, M.D. ADDRESS 308 Gay St., Cambridge, Md. 21613																	
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			27b. DATE 10/24/87			27c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk.			27d. LOCATION CITY OR TOWN Airey, Cambridge, Dor., Md.								
28a. FUNERAL DIRECTOR NAME Curran Funeral Home 308 High St., Cambridge, Md. 21613						28b. DATE REC'D. BY REGISTRAR 10/22/87			28c. REGISTRAR'S SIGNATURE								
29a. BP _____																	
30a. DHMH 17 (VR A15 ME (5))																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exhibited within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed in the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 29015			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Ira G. Wroten									10 1 87			10 P.M.	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 08 11 08			6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter			12b. KIND OF BUSINESS OR INDUSTRY construction			MD.	
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Hurlock			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Glen Oak Circle 21643	
14. FATHER'S NAME FIRST John MIDDLE Wroten LAST			15. MOTHER'S MAIDEN NAME FIRST Angie MIDDLE unknown LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT ADDRESS Rt 1 Box 518 Lettie B. Wroten Hurlock Md. 21643							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____			Respiratory Insufficiency									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) _____ Pneumonia and CHF										
(c) _____ ASCVD: A. Fib													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Dyskinic Brain Syndrome</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE <i>S. Scerriwos</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 10/5/87			23c. NAME OF CEMETERY OR CREMATORIAL MD. VETERANS CEM.			23d. LOCATION CITY OR TOWN BEULAH			COUNTY	STATE MD.
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE OCT 07 1987							
DHMH - 16 60M 7/84 (VRA 15, 4)													

500-130 DECEMBER

ASTORIA - 2 PM  
PENNY CO. STATION - 1 AM

500-130 DECEMBER